



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MOTOR VEHICLES
WASHINGTON, DC 20001



Application for Parking Placard/License Plates for Persons with Disabilities

I am applying for (only check ONE):

License Plates
(D.C. Residents Only)

Parking Placard

Complete this side of the application with all the information that applies to you. Sign in the space provided below and have the application notarized in the space provided. Have your physician complete **Section C** and return or mail it to the Department of Motor Vehicles, ATTN: Medical Review Office, 301 C Street, NW, Room 1033, Washington, DC 20001.

SECTION A: APPLICANT'S INFORMATION

NAME: _____
FIRST _____ MIDDLE _____ LAST _____

ADDRESS: _____
STREET _____ CITY _____ STATE _____ ZIP CODE _____

GENDER: **FEMALE** **MALE** **HEIGHT:** _____ Feet _____ Inches

WEIGHT: _____ **EYE COLOR:** _____ **HAIR COLOR:** _____

SOCIAL SECURITY NO.: _____ - _____ - _____ **DATE OF BIRTH:** _____

TELEPHONE NO.(HOME): _____ **TELEPHONE NO. (OFFICE):** _____

E-MAIL ADDRESS: _____

The applicant swears or affirms the following:

I will use the disabled license plates granted by the Department of Motor Vehicles as provided in Chapter 27 of Title 18, District of Columbia Municipal Regulations, and I understand these disabled parking tags are not transferable to any other person, but are intended for my use only.

I will use the disabled parking placard granted by the Department of Motor Vehicles as provided in Chapter 27 of Title 18, District of Columbia Municipal Regulations, and I will have the designated driver display the disabled parking placard only when I am a passenger in the vehicle in which the placard is displayed.

The above information is true and correct to the best of my knowledge, information and belief.

Applicant's Signature

Date

Any person using a fictitious name or address and/or knowingly making any false statement on this application is in violation of D.C. Law and subject to a fine of not more than \$1,000 or 180 days imprisonment or both. (D.C. Official Code §22-2405).

To report waste, fraud and abuse by any DC Government Official or agency, call the DC Inspector General at 1-800-521-1639.

Applicant's Name: _____ **SSN#:** _____

SECTION B: NOTARIZATION

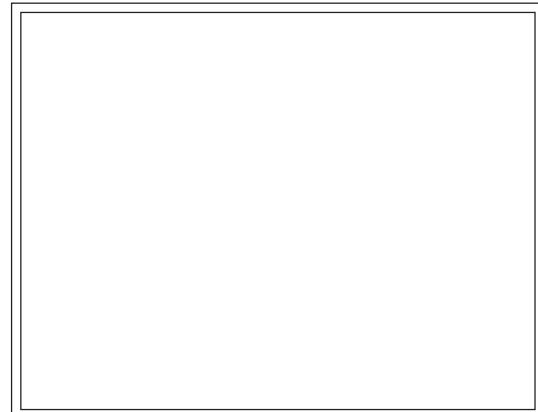
I, _____, being duly sworn, depose and say that
(Notary Public) _____, is the individual making the foregoing
(Applicant)

Application for Disabled License Plates or a Disabled Placard. The answers to the foregoing questions and other statements contained in this application are true to his/her own knowledge and belief.

Sworn or affirmed before me this _____ day of _____, 20____.

Signature of Applicant: _____

Signature of Notary Public: _____



PLEASE PLACE SEAL HERE

Applicant's Name: _____ SSN#: _____

SECTION C: MEDICAL INFORMATION

This section must be completed by a Licensed Physician.

- A. Has applicant permanently lost the use of one (1) or both legs?
- Yes No
- B. Is applicant so severely disabled as to be unable to walk without the aid of a mechanical device (the term mechanical device includes wheelchair, walker, crutches, and long leg braces and may include a cane)?
- Yes No
- C. Does applicant suffer from respiratory disease or ailment, after consideration of the extent that the Aerial PO₂ is less than 60 mmHg, the Forced Vital Capacity ("FVC") is less than 50% of the predicted value, the Forced Expiratory Volume in one second ("FEV1") is less than 40% of the predicted value and the FEV1/FVC is less than 40% of the actual value when measured in liters by a spirometer based on predicted normal values for the individual's sex, age, and height as set forth in Tables 2 through 7 on pages 89-94 of the "American Medical Association: Guides to the Evaluation of Permanent Impairment," 2nd ed. Chicago, American Medical Association, 1984?
- Yes No
- D. Does the applicant have a physical disability that is permanent and that substantially impairs the individual's mobility?
- Yes No
- E. Does the applicant have a physical disability that is not permanent, but that will substantially impair the individual's mobility for no less than five (5) weeks?
- Yes No

Printed Name of Physician: _____

Signature of Physician: _____, MD

Address: _____

City

State

Zip Code

Telephone: () _____ E-Mail address: _____

Date: _____ 20____ Physician I.D. Number: _____

Applicant's Name: _____ SSN#: _____

SECTION D: MEDICAL REVIEW UNIT

This section to be completed by the Department of Motor Vehicles

Based on the information submitted, the applicant is hereby Approved Disapproved

The applicant's condition is considered Permanent Temporary

Comments and Details:

Medical Review Unit Employee's Signature

Date